

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

STATE OF NEW HAMPSHIRE

DIVISION OF HEALTH PROFESSIONS

Board of Medicine

121 South Fruit Street, Suite 301

Concord, N.H. 03301-2412

Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director



TO WHOM IT MAY CONCERN:

In order for a physician to be eligible for a locum tenens license, the Board must receive the following:

1. The completed application and the \$150.00 fee.
2. A letter from **each hospital/health facility** in New Hampshire stating the name of the locum tenens physician **and the dates he/she will be practicing is required.**
3. A letter from the state in which the locum tenens physician holds a full, unrestricted medical license which is current and in good standing. **This medical license must be valid for the entire 100-day locum tenens license period.**
4. **Please be advised pursuant to RSA 329:14, VII, you must have a full unrestricted license in another state to be eligible.**

If you should have any questions regarding this process, please call the Board office at the number below.

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

STATE OF NEW HAMPSHIRE

DIVISION OF HEALTH PROFESSIONS

Board of Medicine

121 South Fruit Street, Suite 301

Concord, N.H. 03301-2412

Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director



APPLICATION FOR LOCUM TENENS LICENSE

PERSONAL INFORMATION:

Name: _____

Home Address: _____

(Phone) _____

Present Place of Practice: _____

Address: _____

(Phone) _____

Business Address for the prior three (3) years (if different from above): _____

Telephone: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number: _____

EDUCATION AND TRAINING:

Medical School: _____ Year of Graduation: _____

Post Graduate Training Institution: _____

Dates of Training: _____

LICENSURE INFORMATION:

State in Which You Presently Hold License(s): _____
Verification of good standing from the state in which you primarily practice and have a current license is required. Verification must be received directly from the licensing board **and the dates of that license must cover the dates in which you are practicing in New Hampshire.**

Many states require payment of a fee for verification. Please check with your state board before requesting verification of licensure.

Have you ever been subject to disciplinary action by any licensing or certifying agency or by any hospital or health care facility? _____ If yes, please provide the date of that action and a description of the circumstances of the action.

Have you ever applied for or requested an application for licensure in the state of New Hampshire? _____ If yes, when: _____

NEW HAMPSHIRE FACILITY INFORMATION:

List the name and address of each New Hampshire health care facility at which you will be practicing. **Each New Hampshire health care facility at which you will be practicing must send a letter confirming the dates of service before the license will be issued.**

PRIMARY FACILITY:

NAME _____ Telephone Number _____

ADDRESS _____

SECONDARY FACILITY: (if applicable)

NAME _____ Telephone Number _____

ADDRESS _____

DATES:

BEGINNING: _____ ENDING: _____

(Valid for 100 consecutive days within one twelve month period)

(YOUR SIGNATURE)

(PLEASE PRINT/TYPE YOUR NAME)

DATE: _____

Please enclose a check in the amount of \$150.00 (nonrefundable) made payable to: TREASURER,
STATE OF NEW HAMPSHIRE.

FOR BOARD USE ONLY:

Received: _____ Fee Paid: _____ Check No. _____

Licensure Verification Form

New Hampshire Board of Medicine

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for a license to practice medicine in the State of New Hampshire. The NH Board of Medicine requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise, directly to the NH Board of Medicine. Kindly mail your response to:

BOARD OF MEDICINE
121 SOUTH FRUIT STREET, SUITE 301
CONCORD, NEW HAMPSHIRE 03301-2412
Tel: (603) 271-1203

Biographic Information:

Last Name	First Name	Middle Name	Gen. Suffix
-----------	------------	-------------	-------------

Mailing Address	City	State	Zip Code
-----------------	------	-------	----------

Social Security Number: _____

Date of Birth: _____

License Number (if known) _____

Signature _____

The following should be completed by the licensing authority and returned directly to the NH Board at the address above.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date: _____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official
Board
seal here

Signature/Title _____

Date _____